BEFORE THE

UNITED STATES DEPARTMENT OF DEFENSE

Washington, D.C.

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In the Matter of: :

ARMED FORCES EPIDEMIOLOGICAL BOARD :

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The above-entitled matter came on for meeting, pursuant to Notice before Dr. Gerald F. Fletcher and Colonel Vicky Fogelman, Moderators, at Walter Reed Army Institute of Research, Building 40, Sternberg Auditorium, Washington, D.C. on Friday, December 13, 1996 at 0800.

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AGENDA

Agenda, Friday, 13 December, 1996

P R O C E E D I N G S

(8:05 a.m.)

DR. FLETCHER: We would like to begin as much on time because of the weather and other elements. I have been advised to advise you, if you have flights maybe to add another 20 to 30 minutes to your time because of the rather tremendous traffic. And transportation, we are working on having that available for you appropriately. So

sort of check with Jean or someone about your times and so forth.

We are going to abbreviate a bit some of our discussions this morning subsequently. I would like to ask Dr. Joseph to make some comments. He has worked us in his busy schedule.

Dr. Joseph, thank you very much, and you can speak to us as you so desire.

DR. JOSEPH: Thank you. Good morning on this beautiful day in Washington. This ain't Colorado Springs. I haven't figured that out yet.

(Laughter.)

Well, I'm anxious to hear what is developing and where you are. This is your first meeting since Colorado Springs.

DR. FLETCHER: Yes.

DR. JOSEPH: We will see what has come out of that. That is of real interest to me.

I guess we are going to spend most of this morning, a good part of this morning, talking about the Persian Gulf, and we will try to bring you up to date on a number of things.

Let me make a few editorial remarks before we go into the session. If this ain't Kansas or

Colorado Springs, the Persian Gulf has sort of turned into Cloud Cuckoo Land. We are in the phase of the flavor of the month of everybody's favorite theory about this or that, and I expect that that will get worse before it gets worse.

What we need is to keep doing the same kind of sober and disciplined work that we've been doing, that you have done for us on the low level chemical side, and keep both the clinical and research activities going at the best pace we can.

The Department took an important step, a very important step, that we had pressed for for some time a month or so ago in mounting a major resource to look back through all the information and the historical record and the much broader scope of issues that might bear on the PGI than simply the medical, clinical and research ones. And that will yield, I think, some very positive benefits within the next few months. I think Colonel Koenigsberg is going to talk to you about that.

Ed, are you here for the Rosker group?

Okay. So we'll go from there. And I will be happy, during the time I'm here, which will be, I think, during all of the morning, to come back to

any specifics or further issues that you want to discuss about PGI.

I think with that, we ought to go right into the business of the morning. I am really interested to see if we -- the schedule sort of slipped my mind for a moment, but if we have some time to talk about where the Board is going and the things that have come out --

DR. FLETCHER: That's on the schedule.

DR. JOSEPH: -- from the Colorado Retreat. That's of real long-term importance.

DR. FLETCHER: Okay. We will move on.

Vicky.

COL. FOGELMAN: Dr. Joseph. I'd like to call Dr. Perrotta up, please.

DR. JOSEPH: No good deed goes unpunished, Dennis.

I don't quite understand the symbolism of this, but apparently Dr. Perrotta is a great fan. He's numbered among those people who have no better sense than to jump out of airplanes.

(Laughter.)

Especially to thank you for your work on the low-level report in good time and jumping out of

an airplane without a parachute, here's a picture of the Golden Knights in full cry.

(Applause.)

DR. PERROTTA: I also happen to manage the Injury Prevention and Control Program for the State of Texas, to tell you what sort of state of affairs that is in.

(Laughter.)

Thanks very much. It was an honor to work on that project, and I'm looking forward to doing even more on it.

DR. JOSEPH: I can give you another one.

COL. FOGELMAN: Okay. Without further ado, I would like to introduce our first speaker, Dr. Ed Koenigsberg, who is the Director of the Investigation and Analysis Directorate for the Special Assistant to the Deputy Secretary of Defense for Gulf War Illnesses. Boy, that's a mouthful. He will be talking to us a little bit about the recent developments and findings in the Persian Gulf.

COL. KOENIGSBERG: Good morning. Thank you for inviting me. It's been some time since I've been here representing the Armed Forces Medical Intelligence Center.

As Dr. Joseph has said, there are new names and new efforts being made by the Department of Defense. A lot of this has been put in the newspapers recently. And I will just very briefly try and go through this and give you some idea of what is being done and some of the areas that we've looked into in the past year and a half, and then finish up by going into a little more explanation about Khamisiyah and the possible low-level exposure at that particular instance.

This is the new chart showing what we're doing within this new Directorate. What has happened is that Dr. Rosker, the Assistant Secretary of the Navy, has been made a Special Advisor to the DECSEPDEF for Persian Gulf illnesses. And the team that we had, that we've been functioning with for the last year and a half, which consisted of 2 clerical people in addition to 10 people doing the actual investigation work, will now be increased to somewhere in the vicinity of 120 people.

So it's a significant increase in the amount of material and people that will be placed against looking at the issues that are out there. They just become overwhelming and, as Dr. Joseph

said, it's become somewhat of a flavor of the month. And every one of these theories, incidents and such will be looked at.

The thing that is different in this program is that we've always done, using these databases and had those available to us. And this was part of the services collecting material for declassification. But more than the declassification, it was just getting all these documents together for the first time so that someone could take a look at it and put it in digitized form where we could search it with a search engine to find out any of the information we needed on specific incidents.

So this part has all existed previously. What is new down here now is the fact of the input and output from the veterans, because that will be increased tremendously. And a lot of the new personnel coming on board are brought on in order to do exactly that, to get back with the veterans and let them participate more in the actual looking at it.

We've been concentrating in the past, and we've already talked to over 2,000 of these people, but we have spent a lot of time looking at the

databases, because that was our main goal. Under the new system we'll do more even with the veterans and be able to continue looking at databases.

Now, if you take a look -- and just to run through it kind of quickly -- the amount of theories that are out there and the possibilities and permutations of what could be causing problems in the veterans, we've been through a lot of these. And many of these have been in the newspapers as you go along. One of the flavors of the month is now this here, pyridostigmine bromide, the article that just recently came out by Dr. Friedman suggesting the fact that stress will break down the blood brain barrier and allow more of the pyridostigmine bromide to go into the CNS and cause symptoms that are different than when given to people who are not under a stressful situation.

I think the immunizations all along have been something that has been suspect and have been looked at tremendously, in significant amount of detail, as to whether there's any possible cause with these vaccines or with the combinations of vaccines.

Infectious agents. I think, as you are

aware, many of these have been on the list for a long time. Dr. Nickelson's theories again back out in the newspapers this week with a new -- in yesterday's paper with a new revelation that indeed some three years ago he was visited by an Iraqi general who snuck into the country and was seen by him and that the Iraqi general says that Saddam Hussain did use chemical or biologic weapons against coalition forces. And he makes the statement that he did do blood tests on this Iraqi general and found mycoplasma in the blood.

And as you are probably aware, the mycoplasma that he is talking about is not a standard mycoplasma but one in which, he states, has an HIV gene tacked on to it that could have only been done by human intervention.

I think in some of these others here, the insecticide, the British are very much involved in looking at pesticides. They use different pesticides than we do, but there's been a lot more interest in the U.K. on the idea that the use of pesticides may be a significant factor here.

The idea of chemical warfare, I think, obviously has been a major factor. And one of the

things that has really sidetracked our smaller operation, because since June we have put almost all of our efforts into looking into this one particular possibility, at the expense of some of the other possibilities that were out there.

The idea of deployment of agents had been accepted. The fact that no agents were deployed against us but that the low level was the major factor in this. Now again, the idea of deployment of these weapons has been brought back up in the newspapers recently, that maybe they could have been in some of the SCUD missiles and some of the other areas that we've looked at.

The low-level exposure, you all helped out at the request of Dr. Joseph and did the research on world literature as to what was out there in the way of low level and the chronic consequences of low level exposure where you do not have an acute exposure initially.

So this is still being a very, very major factor. And many of these things are terribly unclear. Even things such as the Czech detections, which we've given a lot of credibility to. In some visits recently there had been some statements made

by the Czech government that maybe we're putting more credit to their detections than what they would in terms of what was done.

I think the thing that has been the most frustrating about this is that, number one, there are a lot of missing parts when you try and look at any of these items. You can't find records that would substantiate or deny, give you some better idea. And, also, of the records we do have and the people you talk to, since this is now five, six years later, we get very conflicting statements.

We'll have one individual come in and talk about something and say, "I am absolutely positive this happened," and the person standing next to them says, "I am absolutely positive this didn't happen." So it becomes extremely difficult, particularly from a scientific standpoint, to pin down these things. And it puts a lot of it back on conjecture, and that's where we start getting into trouble.

I think some of these others are out there as well that you've heard about in the past, the multiple chemical sensitivity idea and some of the others, the studies that have been done. The Clark paint is a paint that's against a chemical. It's

put on equipment to protect them against chemical exposure. And painting this stuff has also been implicated as a possibility of causing problems.

I would then like to go into just a little bit to give you an example, because this has gotten so much notoriety, is Khamisiyah and some of the problems here, what we know and what we don't know about what happened at Khamisiyah.

Khamisiyah is located in Southern Iraq. It doesn't show up quite as well on here as it does on my slide, but you can see where it's located. This site has been given about four different names. It depends upon the town nearest to it that you happen to use. So it's been called Telelom, it's been called a bunch of other things.

The ammunition site itself is 25 square kilometers, but if you look at the entire area, there are other places where ammunition is stored around it, and the entire area represents about 50 kilometers worth of material that is both munitions, equipment, et cetera.

This is what the ammo dump looks like. And we will be talking basically about three different sites within the ammo dump that give you an idea

where the United Nations teams found anything. We talk about a bunker, Bunker 73, which has gotten a lot of notoriety in the press. We talk about a pit area, which you see down here.

And then there's an open storage area out here to the side, which was removed and was never seen by U.S. troops at the time when they came through here. It's sitting out in the desert, and there were weapons there that were covered with tarps, and no one knew that they were there.

And this represents a problem that was throughout the whole Gulf. Because when we were looking at bombing or doing demolition work on chemical or biologic weapons, most of the material had probably been moved outside the regular storage areas. And it was quite easy to take these in the desert, put a sand-colored tarp over top of them, and we never knew that they were there in terms of our bombing.

The site was never suspected as a chemical site before the war. This was not one of the ones that we had targeted for that. We did hit this site and did bomb the site, and there was damage done. And in the papers they've talked about, well,

there's discrepancies. Well, the discrepancy is that only four of the bunkers were hit during the time of the bombing, but 37 warehouses were hit. And there are two sections within Khamisiyah. One is bunkers and the other is warehouses.

The demolition at the site occurred during a period from about 3 March on, as you can see here. And the troops came in, took a look at this place. There were people, Bedouins, moving all over the area. When they got there, there were dogs running around, kids. The Bedouins were going into the bunkers, stealing material out of it and such.

The U.S. troops came on board, went through the bunkers with explosive ordnance experts, as well as the engineers who were mainly responsible for the demolition. They set their charges. They tried a couple bunkers on the 3rd of March. On the 4th of March was the major explosion with 30 bunkers, 30-some bunkers, that were exploded. One of the bunkers did not go off on that day, so it was detonated the following day.

Because of the fact that during this time there were a lot of what they call cook-offs or blow-offs where rockets were flying out of the area

when they set the demolition charges, they decided to try and do something a little different. So on the 6th of March, they tried to rubble, which would mean imploding the bunkers, blowing them up in such a way that nothing would fly out and that it would all fall inside. It didn't work very well. So they went back on March 10 and did the final 60 bunkers as well as the pit area.

This is a picture of what these bunkers look like. They're huge. They're absolutely huge, and they're filled from ceiling to floor basically with weapons, which makes it extremely difficult to say, "Well, did you go through and look at every single weapon that's inside these bunkers?" Absolutely not. But a good look was taken inside the bunkers. The charges were set inside the bunker, so each bunker had to be visited by the EOD personnel.

And what we know after the war and from UNSCOM is the fact that these weapons were not marked. So there's no way that they could have told, even looking at some of these. As you can see, on the 4th of March, some of the observations, as I mentioned before. The bunker that the U.N.

found to contain chemical weapons, Bunker 73, was blown up on the 4th of March. At this point, there were many fly-outs.

The companies that were there had chemical detectors turned on at the time. One chemical detector went off, all the other ones did not. They ran a second backup test, which is the 256 kit. The initial reports we had that none of the 256 kits were positive. Subsequently, one of the people who was there appeared on television and said that his kit was positive. And it's an individual that we had talked to, so we called him back and said, "You told us that your test was negative. Now you're saying on television that it's positive." His response was, "Yes, but since I spoke to you, I thought about it some more and I think it was positive."

This is what the demolition looked like on the 4th. I guess it won't get much clearer than that. These did not go off as one -- you see pictures sometimes in the paper of this big mushroom cloud. Each bunker went off individually. Because there was no wind blowing on that particular day, it was only about a two- to three-knot wind, eventually

all the clouds coalesced and you see this great big cloud formation that forms over the area. But it was blown up with each individual bunker going off in sequence.

On the 10th, as we mentioned, they did blow up the remaining 60 bunkers, as well as what was called the pit area. And the pit area has been the one that's received a lot of publicity and a lot of problems with it. As far as our troops were concerned, they found about 800 122 millimeter rockets which were unmarked in the area. They were short on explosives, and they went ahead and blew up this area as best they could, knowing that they weren't going to be able to destroy all the rockets that were in the area. But they certainly wanted to put them in some kind of condition that the Iraqis couldn't use them after we left.

One of the individuals who was responsible for blowing up these rockets went back in a couple of days later, and this is a picture of him sitting there two days after the rockets were blown up. And what you see sticking out of the sand here, these are the rockets we are talking about. They have no specific marking on them. They are -- many of them

were still intact. As he looked at these things, he said a good bit of them were still intact that he saw.

UNSCOM goes in in October '91, and they are taken to this site. Actually, they were told that they were going to An Nasiriyah, which is an ammunition site about 25 kilometers north of this, northwest. They were taken to the site. When they got there, they said, "This isn't An Nasiriyah."

And the Iraqis said, "Yes, this is a different site, this is Khamisiyah, and we want to show you some chemical weapons." So they were taken to the pit area and they said, "These are chemical weapons that we have in the area."

They were also told that the Bunker 73 contained weapons, and they showed them this group of munitions. These were 155 millimeter shells that contained mustard gas. They are pristine condition, there's nothing wrong with them. These were the ones that were under the taps sitting in the desert and had never been touched.

Now, when they went into the pit and they showed them the rockets and said, "These are rockets that contain chemicals," there was no way for UNSCOM

to know that there were chemicals inside. So what they did is, they put an individual in a mop gear suit. This is a German-made suit, not one of ours. It came from World War II and from what they were using in factories in those days in making sarin. And this individual drilled a hole in one of the rockets. And what you see squirting up, which doesn't show up very well here, is sarin and cycloserine squirting out of this missile.

So the only way that UNSCOM was able to prove that there were chemicals at that site was to drill a hole in the rocket. And, obviously, when our troops were there, they were not running around drilling holes in rockets to determine what was inside.

UNSCOM went back in March, found additional rockets, a total of 763. And, actually, they didn't find all of them, because they left before all of them were discovered. They left the Iraqis there to dig the rest of them up and to take those rockets that they found up to Al Muthanna where they could be destroyed.

UNSCOM, while they were there, did destroy many of these rockets themselves. Took them to

another site in the desert and did the demolition that was required to get rid of them. At the time, they never looked at Bunker 73, other than to go up and look over the edge of it. They did no testing down in there.

They did do one chemical monitoring test. It was negative, but it was done from the top. It was not inside the hole in the ground that this bunker -- what was left of this bunker.

So there was no real testing done. And the only information we had at that time was the fact that they said that this bunker had been blown up by United States troops, or coalition troops, when they were there in March and that they never talked about the pit. They never said that the pit was blown up by U.S. troops. And there was no confirmation by UNSCOM at that time that actually rockets containing chemicals were in that pit area.

When they did go back in March, they were digging up the rockets. Most of them were buried in the sand. And these are Iraqi soldiers who are digging the rockets up for the UNSCOM people.

This is what the rockets look like. They're quite long. There's no specific markings on

them. And as you can see in many of these rockets, some of the things that are kind of unusual, there's no indication that any of these were burned, as if they were trying to be blown up.

There were a lot of questions in the mind of some of the folks that went on that UNSCOM team as to whether this story had any validity even at that point, because what they didn't find were a lot of burnt boxes. These things had been stored in crates. The wood they saw was not burned, the rockets were not burned. It was very hard to determine whether any demolition had actually been done at this time.

And when the report was brought back to the United States, the fact that there had been rockets in this area, a lot of people were extremely incredulous, that this was a staged event. There were many things going on at the time where the Iraqis were taking UNSCOM people to places, they were blocking them from going into other places.

They had to account for all the chemical and biologic weapons, so the feeling was if they take you somewhere and say, "Oh, here's a couple thousand rounds of something that you all blew up,"

then that takes care of accounting for those 2,000 rounds that they need to identify.

So there was a lot of question at the time when this report came out and not a lot of credence was put in it. And the main thing that people were looking for at that time, because there was no such thing as Persian Gulf illnesses, was the accountability of where rockets and chemical and biologic weapons are and can we say that he's gotten rid of this. And that was the goal of the UNSCOM, the intelligence community, as well as everyone else.

In May of this year, UNSCOM went back again and took a look at the site. And this is when we finally got the information that gives the most credence to some of what really went on, because they did go down into Bunker 73, and they found enough evidence that they feel would indicate that there were chemical weapons that had been at Khamisiyah.

They also were told the story here that 2,100 rockets were brought down from other places into that area from Al Muthanna right around the beginning of the air war to get them away when we

were bombing the sites that some of these -- Al Muthanna was one of the places we were bombing, so they brought these down into this area.

They brought down, in addition, the 6,000 mustard rounds were brought down from An Nasiriyah. And the bunker up there that was seen by UNSCOM that they came out of. There was no indication that chemical weapons had been hit during the bombings of An Nasiriyah, which had been done during the air war.

They said that these weapons were put into the bunker, the 2,100 rounds, but some of them started leaking, so they took about half of them and moved them out to the pit area. Now, they had previously, on the first rendition of this, had said the stuff in the pit area was salvaged from Bunker 73. And the thought was at that time that they meant this had been taken out after Bunker 73 had been blown up. It turns out now that what they really meant was that these were taken out before any demolition was done at the time so that those rockets would have been blown up inside the pit area.

This is what Bunker 73 looks like

currently. As I said, a hole in the ground. And it does have the rockets still in that area. And when they took a look at the rockets, this is what they're seeing that confirms to them that these were chemical rounds.

Once the rocket is split open, you can see that there's a liner inside here. And when you're putting chemicals inside, it's important that they have basically a plastic liner that's inside. It also has a different kind of filler cap on a rocket that contains chemicals in it, and it also has a small explosive charge in the middle that disperses the chemical when the rocket goes off. All of these are internal. There's absolutely no way on the outside to see any of this that would tell you that this is a chemical rocket.

Now, one of the last things that I might mention is, people say, "Well, why wouldn't Saddam Hussain mark his rockets and how could he tell which ones were chemicals and which ones were not?" And what we've gotten from their policy on how they work this is the fact that from the time they fill their rockets, they assign a team to go with those chemical rockets to the site where they are going to

be deployed. And that team stays with the rockets the entire time, so they don't need to have it marked.

When it comes time to launch a chemical rocket, they launch it out of regular conventional rocket launchers, but the people who normally launch the rockets will back away. These special forces people will then go up, take their rockets with them, put it in the launcher, reset the calibrations, fire the rockets, back off, and then the people who normally work with that rocket launcher will then come back on board again. So there is not the same need to have some of these marked.

Since they have rockets from all over the world, yes, there are some that could have been marked, but for the most part these are not marked rounds. And in the things that have put in the newspapers, such as the fact that some of these rockets seen, or some of the munitions seen in this dump had yellow tops to them, the picture that's been in the newspaper and has been shown by some of the people to say that these rockets were there, it turns out it's a picture from James Magazine of a

munition that's made by the French, and it's a tank munition. It's not anything that could even be used or considered for use in spread of chemical weapons. These are tank rounds.

And what you are talking about here are people who are not explosive experts who are going in and seeing something marked. They were told at the beginning of the war to look out for anything that had circles or bands or yellow markings or anything else on them, so anything that met that description was considered by them to be a chemical round. When someone looked at it who had a little more knowledge and said, "No, this is not a chemical round, we can go ahead and blow it up," then there was still some thought in some people's minds that these were chemical rounds.

I think the issue, in essence, and the bottom line to all of this, is Khamisiyah is still not 100-percent clear-cut as to what went on at the site. UNSCOM went in five to six months later, and this is what they found. They were able to find it because the Iraqis told them that there were chemicals there and they were able to drill a hole in one of the rockets to find that it was there.

I think one of the things that many of us who have looked at this are somewhat concerned about, because the newspapers have talked about the incompetence of our troops that went in there, and I don't think that's an issue. I think these people did what they needed to do. And the fact that we can go back now and find some things, it only points out one factor to me, that we don't fight a war to do research and to prove that something is there. They had other things on their mind at the time, and they did the job that they were supposed to.

That, in essence, then, is my contribution this morning. And, Vicky, if you want to move on to the next speaker.

COL. FOGELMAN: Thank you.

DR. FLETCHER: Thank you very much.

COL. FOGELMAN: Do you want to ask for questions now?

DR. FLETCHER: Brief comments and questions from whom? Mr. Chin.

DR. CHIN: The units that blew up those sites, what kind of numbers and have any of them been reported to have the syndrome?

COL. KOENIGSBERG: The numbers that

actually were involved in the demolition itself is somewhere between 150 and 250 people. They were small segments that were taken from larger numbers, larger units. In order to find out which 150 to 250 people were there, we had to canvas the whole 1,100 people that represent those units, the entire unit.

Now, most of the unit was somewhere else. There was only 150 to 250 of these units that were actually in the site. The people that do the CCEP went back and took a look at the medical records on these people. And it turned out that there was something like 46 people out of this group that were in the group that were at Khamisiyah.

When we went back and located these people, about 43 said that they were actually at Khamisiyah. There were 46 in the total 1,100, but there were only, as far as we know right now, there was only about 43 of those that were in the CCEP database, the comprehensive clinical evaluation database.

Dr. Joseph had people looking at this. They set up a system where they actually pulled the medical records on each one of these 43 people. They were reviewed by military physicians, they were reviewed by outside physicians outside the military,

to take a look at it to see if there was any difference or anything in these records that would look suspicious. And my understanding is that there was nothing different in these 43 records than in anyone else that was from the Persian Gulf or elsewhere.

DR. CHIN: Were any of them self-reported --

COL. KOENIGSBERG: All of this is self-reported. The CCEP is based on self-reporting. You don't get into it unless you bring yourself in. There's no effort at this point to go out and say everyone has to come in. The offer has been made for everyone to come in. And what we are currently doing, we have sent letters to everybody we can find within a 50-kilometer radius of this site. We have sent letters suggesting that they get into either the Veterans Administration registry or the CCEP and have an evaluation.

And we have a survey that will be going out after the first of the year asking further questions about what they saw and heard and did at that site, and again recommending to them very strongly that if they are having health problems they should get into

one of the registry programs and get evaluated.

DR. FLETCHER: Other questions or comments?

DR. GWALTNEY: When you say mustard gas and sarin, is that the same thing? Are you using those terms interchangeably? Is sarin the only chemical we are interested in?

COL. KOENIGSBERG: No, we're looking at any of the agents that are out there. The mustard and sarin are not the same, obviously, and we are talking about two different things.

The rockets contained sarin and cycloserine at Khamisiyah. The mustard rounds, which were the ones I showed you that had not been touched and had not been damaged, so we have no indication that there was mustard released at Khamisiyah. The only suspicion is related to the sarin and cycloserine.

DR. GWALTNEY: Were there any other toxic chemicals besides those two discovered?

COL. KOENIGSBERG: Not at Khamisiyah, no.

DR. FLETCHER: Other questions or comments?

Thank you very much.

Let me acknowledge, before we go on, two people. Dr. Rus Luepker, one of our former members, is here at the table. And Dr. Julian Haywood, one

of our new members of the Board.

Julian, would you please stand?

We will move on. The next two speakers we have asked to abbreviate their discussions briefly because of some of our other issues we need to discuss this morning. We thank you very much for doing that.

Vicky, I'll let you introduce them.

COL. FOGELMAN: Okay. Our first speaker will be Dr. Chip Patterson, who is Deputy Director of Scientific Activities at Health Affairs, and he will talk to us a little bit about the clinical issues related to the Gulf.

COL. PATTERSON: Good morning. I am going to briefly highlight some aspects of the Comprehensive Clinical Evaluation Program clinical results, which has some pertinence to some of the health issues related to possible exposure to chemical agents.

Before I do that, I want to highlight that the CCEP was never designed to discern issues related to exposures. It was a clinical program, a program to deliver expedited care to veterans concerned about their health. To date we've

completed evaluations on approximately 23,000 individuals. In that sense, it is in essence a very large descriptive case series. And we have utilized a structured clinical protocol to try and ascertain health outcomes, health outcomes that may or may not be related to events that occurred four or five years ago.

However, there are, as you can appreciate, significant limitations in interpreting the CCEP clinical experience. Most importantly, that this is a self-selected set of individuals. We aren't really sure who was actually present at Khamisiyah. Our ability to determine where individuals were in theater is very limited. And we really have an absence of objective measures for exposure classification, neither clinical data nor objective measures of monitoring at the time of the event.

I just want to real briefly touch on some aspects of the results that we have related to exposure history, symptoms and diagnoses. This is from our 18,000 report that was released in April, which I believe you may have copies of previously distributed. And I encourage you, if you have interest, to refer to that.

But you can see from this that we have fairly high frequencies of reporting of such things as chemical alarms. Dr. Koenigsberg mentioned the vaccine issue. Approximately 50 percent of our folks indicate that they took the anthrax vaccine. It's difficult to interpret this data. Certainly recall bias must be considered. In the case of anthrax, for example, our best guesstimate is that probably 150,000 of the total 700,000 deployed force probably received anthrax. So either there's a problem here with recall or else we've got disproportionate participation in CCEP.

I think that to put this into somewhat of an objective context, if you look, for example, the mot- tox vaccine, approximately 25 percent of our participants indicate they received it. We know that a very small number of individuals actually received that vaccine. In our ability to look at some logs and some objective records of approximately 1,400 individuals that received that vaccine, only a very small percentage, less than one-half percent, a handful, are actually in the CCEP.

The other thing I would point out, for

nerve and gas agent, approximately 4 percent of our people indicate exposure.

This symptom profile is something that I think that you've seen in the past. Headaches are very common, memory loss, sleep disturbance, difficulty concentrating, depression. Now, how does that correlate with diagnoses in the CCEP? This is a pie chart of the primary diagnoses out of the 18,000 that we evaluated as of April of this year.

Predominant diagnostic categories are musculoskeletal, psychological, signs, symptoms, ill-defined conditions. When you look at this closer, you see that in terms of individual specific diagnoses in musculoskeletal, approximately 70 percent of those diagnoses involve pain and joint lumbago, osteoarthrosis, myologies, myositis.

In psychological, interestingly enough, the most common diagnosis is tension headache, representing about 20 percent in this category. Other predominant diagnoses, depression disorder, prolonged PTSD, major depression. And about 3 percent within this category, pseumetaform disorders.

Signs, symptoms, ill-defined conditions, an

interesting category. Here approximately 60 percent of these diagnoses involve either malaise, fatigue, sleep disorders, and also headache.

Only about 6 percent of our participants had a primary diagnosis in the nervous system, consisting primarily, predominantly, migraine headache. And 63 percent of the diagnoses in that category were migraine headache, followed by carpal tunnel at about 10 percent.

Overall, we see very few cases of peripheral neuropathies. One thing that has been noted, there is a small percentage of demyelinating disorders, about 1.4 percent.

These are some of the activities currently either planned or in progress, to perhaps use a CCEP clinical experience to at least partially address some of these health outcome issues. As Dr. Koenigsberg indicated, we have looked at a subset of records, roughly a small number, 46, both CCEP records and actual hospital charts when available. And, as Dr. Koenigsberg indicated, that review did not result in recognition of any unusual patterns of illness. Most notable, no cases of peripheral neuropathy.

We intend to, as we are able to discern those individuals that either self-report being present in the Khamisiyah region, or that we are able to document having been present in the Khamisiyah region, looking at the sorts of information that we have in the database, rates of participation for those units represented, symptom frequency, distribution of diagnostic categories, and trying to get a perspective of how that may vary in those units in proximity to Khamisiyah to others.

The last item involves our continued collaboration and work with the Institute of Medicine to review the CCEP, particularly the protocol, and consider whether or not changes are indicated in light of recent disclosures about Khamisiyah and the issue as to chronic long-term health effects possibly related to sub-clinical episodic exposures. We expect to have a report sometime early to mid-1997.

That concludes my talk.

DR. FLETCHER: Thank you very much.

Any questions or comments for Dr. Patterson?

(No response.)

Thank you very much.

COL. FOGELMAN: Our last speaker will be Dr. Gary Gackstetter, Senior Policy Analyst at Health Affairs, who will talk about the ongoing research efforts related to the Gulf War.

DR. GACKSTETTER: Thank you. I promise that this will be very short. I would like you to turn to page four, the seventh slide. And we will keep this under three minutes.

The research program, just a couple of points I'd like to make, is a massive effort. Not only is DOD involved, but whether we like it or not, we coordinate almost every day with the VA program, with the HHS representatives. And it not only includes those three big agencies, but we're also well coordinated with the U.K. effort and with the effort that's going on in Canada. So we are doing anything but operating in the dark here. It's a massive effort.

The next piece that I wanted to show you, in front of you I left this handout, and I really just copied the exact sum of the most current version. And it is so current that I can't give you the whole piece. But if you are interested, please

let Colonel Fogelman know, and I'm happy to send you all 114 pages. And that should be ready -- in fact, it's being printed as we speak. So that should be ready any time.

The exact sum, I think, does a good job of summarizing what we have, but the details are really involved in the pages that follow. But if you let me know or let Colonel Fogelman know, I'll get you a copy of that whole working plan. The idea is that this is going to evolve with time and that there probably will be annual updates to this.

The other thing that I included for your information is just a list of what DOD is doing. I did include some VA projects and the HHS work, as well. So just to give you a sense of what's going on, that's what this page is.

And I think the most important piece is the thing that I grabbed off of the Commerce Business Daily. Two pieces there. One, the BAA that we had written and published, broad agency announcement, asking for proposals. Those protocols came in. About 111 protocols came in, 12 were selected, about $7.3 million. So I included those 12 projects in this pack.

And then on the 10th of December, and that's really the most important piece today, we published another RFP asking for protocols to do two things. One, to look at the feasibility of doing epidemiologic studies. And I don't have to tell anybody in this room how tough it is to do epi with questionable exposure data and very soft outcome data.

So I'm looking for creative epidemiologists out there who can come up with is it feasible or not, or if it is, then can we. The second piece of that is just as important, and that's to look at animal models and subclinical or asymptomatic exposures to very specific chemical weapons.

That RFT, the last paragraph says about $2 million, and I think that will be amended to somewhere higher than that. But if you would distribute that RFP as widely as you possibly can.

The last piece that I wanted to mention is the press announcement regarding the CCEP database. We took out all the personal identifiers, and that database is available, if anybody is interested. So if you know of somebody in your institutions, or if you personally are interested in looking at this

database, then we are happy to show you the process of getting that massive database. It's a huge piece.

The research effort is a whole day's talk, but that's it in a nutshell, three minutes. Stop the clock. Questions that I can answer?

Yes, ma'am.

DR. SOKAS: On your slide number six, you talk about biomarkers as a continuing gap. What's happening in terms of looking for the potential presence of either samples stored someplace or things that you can run on those samples, tests that you can run?

DR. GACKSTETTER: We do have human samples stored sera. The biomarkers, that's an interesting area, because it's very difficult to get biomarkers, the ones that you need. The area -- the gap is definitely find some biomarkers that are credible or that are valid. So that's why that is listed as a gap.

DR. SOKAS: And who is working on that basically?

DR. GACKSTETTER: A couple of units, a couple of groups are, but that's what the RFP is for

as well.

DR. FLETCHER: Dr. Allen.

DR. ALLEN: With regard to potential exposures to any of these chemical agents, I take it that there are a number of different markers. They talked about the monitoring stations. What is the sensitivity and specificity of those? And I realize that some of that may be confidential information. But, secondly, with regard to also when Khamisiyah was blown up and so on, was that sufficiently late in the process? Were troops already being removed from the area or was that close to the end of the four-day war itself?

DR. GACKSTETTER: I doubt --

DR. JOSEPH: Let me speak to that, Gary, and I think Ed may have something.

To put this back in context, during the war and after the war and constantly since the war, there are a series of mechanisms that monitor weather patterns in the Gulf and elsewhere. We are now talking about in 1996 going back and trying to ascertain what specific weather patterns are or were in a limited geographic area between March 4 and March 10, 1991.

The discussion about the CIA model, which is what you are really alluding to, involve the CIA trying to get a fix by several means on weather patterns and dispersion patterns during that period over that piece of real estate, cranking into that an estimated amount of munitions that were exploded -- I think you could tell from Ed's presentation that it's not clear how many rockets were where and how many were blown up under what conditions -- and then making some estimates from that, a third sort of area of great uncertainty, some estimates from that about where various concentrations of dispersed agent would be given the estimate about amounts of munition and the estimate about weather pattern, a process fraught with uncertainty.

That is really the basis of what has been reported repeatedly in the newspapers as the DOD changing the numbers to enlarge the number of people exposed and has been presented as sort of a concern by DOD that we have greater and greater numbers of people that we are somehow concerned about having been exposed.

What actually happened is that we began by using as a model for presumed exposure those

individuals who were actually involved in the Khamisiyah demolition itself. Then as the CIA began to work their model of what a dispersion pattern might have been and what levels of agent over a 72-hour period one might have thought might be in that dispersion plume, they took larger and larger concentric rings to make sure that if indeed there was that dispersion we had all troops in the area or all units in the area covered in the model.

In truth, there really is no data presently as to what the actual pattern of dispersion or concentrations of dispersed agents were. It is all very much a matter of supposition.

Ed, have I got that right? Is there anything to modify?

LT. COL. DeFRAITES: No, I think you hit it. Just to get a little more specific in numbers from your question, the M8A1 alarms that go off, go off at .1 milligram per meter cubed. The 256 -- vehicles are a magnitude further down more sensitive. Your levels of where you start to see any kind of symptoms in people is somewhere around the level of the .1 milligrams per meter cubed.

And the thing you have to understand, and

what Dr. Joseph was saying, about the CIA model, when they started expanding this out what they went to was a 72-hour safety level which takes it down to .000003 milligrams per meter cubed over a 72-hour period. So they took a level of which you would not see any symptoms whatsoever, and they went out with it to a safety level. It's not a level that is set up to detect symptoms or to be tied to anything chronic or anything of that nature.

DR. JOSEPH: And then we doubled the radius out from that. That's where the 50 kilometers 20,000 troops came from. We took that OSHA standard of exposure under a worst case scenario and then doubled the geographic radius out from that.

There's nothing currently in any of the medical logs or any of the individual recollection of the medics in the area during that period of any acute symptomatology.

LT. COL. DeFRAITES: And I think that's a key point. We had discussed with the medical personnel all along, and they have said there is no --

DR. JOSEPH: -- if indeed there was exposure, whether there are chronic symptoms to a

low enough level of exposure at the time that nobody saw any acute or nobody recognized --

DR. ALLEN: So even with the chemical detectors that were available at or near the site where the dump was blown up, the Khamisiyah dump, there's even question, if I heard your presentation correctly, as to the interpretation of the tests.

DR. JOSEPH: Absolutely.

LT. COL. DeFRAITES: Absolutely.

DR. JOSEPH: If we did not have the specific indication that we know that there was sarin in at least one rocket because somebody drilled into it and got a face mask full of it, you would have a very hard time sustaining the argument that there was exposure.

DR. FLETCHER: Dr. Clements?

DR. CLEMENTS: Is anything being done to track the other coalition members, the other troops from other countries to see if they are having parallel problems? Is there also an exchange of information on that?

DR. GACKSTETTER: Absolutely. In fact, almost daily. Study 12, you'll note, in the BAA process was a study that we funded in the U.K. to

look specifically at that coalition member, that coalition partner. And they just recently initiated some epi studies, and we'll come back and do that again. That's really the closest tie we have, is to the U.K. They in turn, I think, are looking at some other groups out there, but that's our closest group.

DR. FLETCHER: Other comments or questions?

Dr. McGinnis.

DR. McGINNIS: What kind of problems are you finding as you try to model the anticipated patterns of problems in the general population of the sorts of symptoms you are seeing in these troops?

DR. GACKSTETTER: That's a great question. The problem is a comparison group. There is no great comparison group. The perfect comparison group doesn't exist. I've got a very healthy group that I deploy. I've got a very healthy group in the military. I take the healthiest of that and deploy them. A healthy worker effect takes on a brand new meaning. It really is healthiest worker effect. So that's the key to success.

What we've done so far with our clinical

program is really numerated based, self-selected numerated base. The key to getting to is there a difference is what's going on in a random sample compared to what's going on in a great comparison group.

Those epi studies are out there, they're cooking along. CDC, HHS and Greg Gray's work so far tells us that there's no question that if you went to the Gulf you also self-report more symptoms and more exposures than if you did not go to the Gulf. The key there is self-report.

When we look at objective measures like handgrip strength, like pulmonary function tests, for any of the CDC was unbelievably fail. All of those objective tests --

DR. McGINNIS: Or the hospitalization and mortality studies.

DR. GACKSTETTER: Yes, exactly right, sir, either the hospitalization or the mortality study. All of those objective hard tests show us no ability to discriminate exposure or no ability to discriminate deployment status. So the self-reported piece is what gets reported, and a lot of stuff gets left off in the newspaper.

But I think as we get further along, we'll get some answers back from the U.K., from our big epi studies that are out there right now. I think that's the key. Without a control group, we can't say much.

DR. FLETCHER: Other questions or comments?

Dr. Luepker.

DR. LUEPKER: Gary, you mentioned the British. Are there other coalition forces that are looking at this or, given the weather patterns, other civilian reports as well?

DR. GACKSTETTER: One of the gaps that we identified was not only coalition partners but understanding indigenous populations. As you know, with multi-center studies and multi-international-center studies gets to be very challenging. And we haven't filled that gap yet and may never.

But other than the U.K. work and their ties to the French, the French essentially have not agreed to play. They don't recognize a problem and are happy to stay with that.

DR. JOSEPH: There are a series, Rus, of impressionistic reports, starting as early as '93, of people who have gone out and talked to and looked

at the Gulf coalition forces, talked to the Kuwaitis, talked to the Saudis, talked to health authorities about civilians in the area, et cetera.

There was a trip made by the now Army Surgeon General Ron Blanc in early '94, and he visited many of the coalition partners and was in the Gulf and talked to both the military and civilian people there. All of those impressionistic reports give no account of increased incidence or prevalence of any of this mysterious illness, recognition of the syndrome or whatever. But there's nothing that's any more science based than that.

DR. FLETCHER: Other questions or comments?

Thank you very much.

(Applause.)

Thanks to all of you for those discussions.

I think we will move next into some very important issues for the Board of review of the charter and proposed procedural changes prior to taking a break.

All of you have the charter in your packets. I would like to review briefly just some

points of the original charter of the Board before we go into the proposed procedural changes with reference to terms, members, et cetera, that Dr. Joseph has reviewed previously. He will be here to certainly have input as he so desires.

The charter of our Board designates -- I'm just highlighting a few points -- that we have approximately 15 to 20 members, and this is variable from time to time. There are consultants in addition to this. But roughly our Board is 15 to 20 members. And these are nominated by the Surgeons General, that is why we are here, and appointed by Dr. Joseph in the Department of Defense.

These are terms for two years. And hopefully we can make them better to be staggered. At this point they are not staggered as we would so like. The members elect from themselves a President who serves two years and can be re-elected, but that's just not a big issue or change now.

Ordinarily, the Executive Secretary rotates among the services. However, I believe the last two have been -- so I think that is not a major issue, but in the charter it says such.

There are committees. The reason these are

subcommittees is because the Board is designated as an Advisory Committee. It's sort of a play on terms, and I was in error when I was saying we should be committees. The Board is actually a committee, but we call it a Board. So the reason we have subcommittees, we have a subcommittee of a committee that's really a Board. But that's sort of a play on terms. For the record.

(Laughter.)

The committees are three in number. And we thought about, and we do have, the ad hoc committee that Jim Chin is dealing with, but we will decide if we want to add another person that we have designated for three committees, Health Promotion, Chronic Disease, and Environmental Quality, and I believe Injury Prevention to further extend the name of that committee.

To highlight a little bit more here, and when necessary, the Board can add ad hoc committees. And I think these are committees we will be doing more of in the future.

The duration, we are looking in Part D where it says actually the Board is a Federal Advisory Committee. That's why we have

subcommittees.

We are, as stated previously, in advisory capacity to the Department of Defense. We are appointed by the Surgeons General. We act in our capacity to advise the Department of Defense. And we are getting more -- we respond to certain questions that are designated for us.

The Surgeon General of the Department to the Army really is in charge of many of the activities of the Board over and above the other services at this point.

And last but not least, the operating annual budget is about $150,000. I'm not sure how that comes into play right now, but that is designated in the charter.

And meetings are to be held three to four times per year, as we state, and we are designated in the charter to have ad hoc committee meetings as need be, or committee meetings. And we're talking more about having telephone conference calls.

So these are sort of the general guidelines designated in the charter, which I thought we would highlight a few points.

And before we go into the proposed

procedural changes, any questions or comments, Dr. Joseph, that maybe you should interpret or add to?

DR. JOSEPH: No.

DR. FLETCHER: Any questions or comments?

(No response.)

Okay. Now, the proposed procedural changes. Does everybody have this? One page typed in very large type that Colonel Fogelman and I put together with the help of a few others. And Dr. Joseph has looked at it. And these are proposals. Please, if you have thoughts or considerations or don't agree or whatever.

We think an Administrative Cabinet should be formed -- we thought about calling this an Executive Committee, but Administrative Cabinet seemed to be more of a trendy thing in our current ways of doing things

-- consisting of the Board President, President-elect who we will do at the appropriate time, Past President, Executive Secretary, permanent subcommittee Chairs, and, of course, the Assistant Secretary of Defense for Health Affairs.

The President-elect will be designated by the Board approximately one year prior to the end of

an incumbent President's final term. The retiring Board President will serve as immediate Past President until new elections are held or until he or she leaves the Board.

And this one is important here. Although most Board members will be limited to two consecutive two-year terms, certain members as designated by the Administrative Cabinet and approved by the Secretary of the Army Committee Management Officer, who looks at all of these, will be authorized to serve an additional two-year term. Now, this will be the change. Right now we do not have the capability, but this will be the change that we are proposing.

Certain individuals may be selected to serve as consultants -- and this has been going on in the past, I think -- to the Board after their terms on the Board have expired. Consultants may not, however, serve as President or permanent subcommittee Chairpersons but may participate in Board discussions and provide input. And these have been very important inputs in the past, as I understand, and still are.

Board members will be permanently assigned

to one standing subcommittee but may serve on others at the request of the President of subcommittee Chairperson. So there may be some overlapping of committees.

Subcommittee Chairs will serve for as long as they remain on the Board unless they resign or are elected President of the Board, at which time a new Chairperson will be selected.

Permanent and ad hoc subcommittees will select an assistant subcommittee Chairperson who can act for the Chairperson in his or her absence.

These are what we are proposing. I really would like any comments. So comments or questions? It is the first time I am aware of we have really changed this procedure. A lot of interest has been in favor of this.

Maybe Dr. Perrotta or some -- Dr. Allen.

DR. ALLEN: With the Administrative Cabinet, would the Past President continue to serve on that and come back even though he or she may have rotated off of the Board?

DR. FLETCHER: If the proposed Past President is off the Board, he would not be on the Cabinet. But if there are in actual continued

membership they would be. So I guess --

DR. ALLEN: It seems to me with our current standard procedure of two two-year terms that it's likely the President would serve a third or fourth year. And I think we will have a fairly high probability that the immediate Past President is not going to be on the Board.

DR. FLETCHER: That will be determined. What I think we're looking at, Jim, is are the people interested in serving that third term. If they are, I think the process would appoint or designate that person. And that indeed may be the case, that that Past President will be on another two years.

COL. FOGELMAN: That person may be assigned as a consultant, also, if we have reached our maximum number of Board members, which we're not allowed to exceed. But I think if the Board wishes, we could try to do that, make sure that the Past President remains as a consultant.

DR. JOSEPH: My question was the same. Until this discussion I thought point three was an impossible situation. But you are suggesting that the retiring Board President could be appointed for

another two years.

DR. FLETCHER: Yes. Anyone on the Board can be reappointed --

COL. FOGELMAN: Or as a consultant if we have exceeded our total number of allowable Board members.

DR. JOSEPH: And hence served on the Administrative Cabinet.

COL. FOGELMAN: Yes.

DR. JOSEPH: Okay.

DR. FLETCHER: Dr. Stevens.

DR. STEVENS: Is there in particular an implication that it would be an advantage to have the Past President -- that should be automatic because they're on it another year.

DR. FLETCHER: The consideration is, having done that, there's a lot of experience to deem by being the President. I think that valuable experience should be present on the Board, and I think we can make it as firm as need be.

PARTICIPANT: I'm quite happy to leave this unstated, but could you just say something about the function of your Administrative Cabinet? I mean, maybe just leave it ambiguous, that's fine, and

allow the usual privileges and prerogatives --

DR. FLETCHER: Let me give my thoughts. In some other organizations, I think we have needed in large a group that can quickly maybe make a decision about something when we can't pull together the entire Board. Or just a group as a sounding board for certain issues. And it's sort of -- my experience in other organizations, it's good to have a smaller group that you can make a decision to represent -- like the committee Chairs represent that committee and so forth. And that's very general.

Are there any thoughts, Dr. Joseph or Vicky or anyone, that are any more specific?

COL. FOGELMAN: Well, there's one thing that's stated in here, which would be that the Administrative Cabinet would have to determine who would stay on for a third term.

DR. FLETCHER: Based on the interest of the members that we put on for a third term.

Other comments or questions on this?

(No response.)

By the way, Dr. Judy LaRosa is the new Chair of the Subcommittee on Health and Emotion.

Judy, we really appreciate you --

DR. LaROSA: Thank you. I definitely appreciate Dr. Fletcher's helping engineer that.

(Laughter.)

DR. FLETCHER: It was a very unanimous --

DR. WARNER: It wasn't unanimous, I don't think Judy was in favor of it.

(Laughter.)

DR. LaROSA: Thank you very much.

DR. FLETCHER: Dr. Chin.

DR. CHIN: Vicky, could you get us some numbers as to how many are rotating off and how many new ones --

COL. FOGELMAN: I don't have the exact numbers with me, but right now I think probably about 75 percent of the current Board members, not the new people but the people that were on the Board, were scheduled to rotate off. And some of those will be asked to remain for an additional term or as consultants. So we will be working that issue over the next month or so. I don't have the exact figure with me.

DR. CHIN: Approximately.

DR. FLETCHER: It's probably three-fourths.

COL. FOGELMAN: Probably 15 or so.

DR. FLETCHER: I think those of you who are interested --

DR. WARNER: The total is 20?

COL. FOGELMAN: Right.

DR. WARNER: About 15 of us are rotating off.

COL. FOGELMAN: Jean, do you have the numbers just off the top of your head of how many people are rotating off or due to rotate off next year?

DR. FLETCHER: By a show of hands, who is in their fourth year?

(A show of hands.)

That's it. So all of this group.

Dr. Waldman.

DR. WALDMAN: Just out of curiosity, are the terms clearly defined when they begin and when they end?

COL. FOGELMAN: They will be defined as of the date of your appointment. And you should receive a letter when you are appointed stating the date of your appointment.

DR. WALDMAN: It could be different --

COL. FOGELMAN: Generally the way we have to work the paperwork through the system, they do seem to be cohorts. We're trying to split those up a little bit, at least by month. It's not quite as easy to do as it sounds like it should be. But we do have cohorts, yes. Probably groups of about five or so at a time.

DR. WALDMAN: Does the Board run on a fiscal or calendar year? Is this the last meeting of the year or the first meeting?

COL. FOGELMAN: This would be the first meeting. What month is it? December. Right, first meeting.

DR. FLETCHER: Dr. Barrett-Connor.

DR. BARRETT-CONNOR: I was curious to know how and who decides how many standing versus ad hoc committees there are? And when an ad hoc becomes a standing committee, how is that decided?

DR. FLETCHER: We are just getting -- there are three standing committees to start with. And we have at this point the subcommittee that Jim Chin -- Epidemiological Surveillance. So I think that would be an issue for the members of the Board to decide if we change the committee structure. And I think

that can be done --

COL. FOGELMAN: If I could just comment. This was discussed at some length at the offsite, and the notes that I took were that the Board was fairly happy with the existing committee structure. There was some discussion as to whether the Surveillance Committee should be a permanent committee or not, but the final outcome, at least from the notes I have, was that it would be an ad hoc committee. So there was discussion of this at the offsite. It doesn't mean it can't be changed in the future.

DR. FLETCHER: Dr. Chin's ad hoc committee, if the group felt this was that important that they should be a permanent subcommittee, then the group would consider that and vote on it or whatever.

Dr. Sokas.

DR. SOKAS: Actually, it wasn't that it wasn't considered as important, it was considered to be very important, but that other people in all the different other standing committees would want to participate in it and maybe being ad hoc might be helpful to facilitate that.

DR. FLETCHER: There is some advantage in

ad hoc and task force and these type things, as all of you know.

Other comments or thoughts?

COL. FOGELMAN: Now, I should make one comment, and that is that these procedural changes would not necessarily go into the charter. We want to keep the charter fairly -- I don't mean to use the word "vague," but it is the first one that comes to mind. However, we will publish these -- procedural changes and we will distribute copies to everyone. Because the charter is much more difficult to change. We just need to have some rules, and I think these could live outside the charter and still be rules that we all accept.

DR. FLETCHER: Are there other comments or questions? I think we have most everyone here. I really would like any thoughts of any way we need to change this. If not, I really would like to have this motion for approval and whatever.

Dr. Broome.

DR. BROOME: Just one comment. I think there is merit in having continuity, but I think there is also merit in having new folks coming on. So I would hope the Administrative Cabinet, or

whatever, would be conservative in applying the third term option.

DR. FLETCHER: The third term will certainly be such that if it's people that are doing something continuously, like some of our committee assignments for the G6PD or -- these are ongoing very important things. And one individual is very interested in staying on, I think these are the type of considerations. But certainly we need the variety of new people, new faces and so forth.

Any other comments or questions? Please feel free. These can be changed.

Do I hear a motion to --

DR. JOSEPH: So moved.

DR. FLETCHER: So moved. Is there a second?

DR. GWALTNEY: Second.

DR. FLETCHER: Any comments or discussion?

All in favor?

(A chorus of ayes.)

I think that's more or less unanimous.

We will take a break now before we go into committees and other issues.

COL. FOGELMAN: Right. The only other

thing I would ask you to do, if you don't mind, if you have not looked at the Executive Summary, please do. If you see anything in here that you don't think is correct or you think needs to be added, please let me know so that I can publish this as a final as soon as possible.

I did publish the Mission Statement as it was written by the Board, and I'm assuming that you still agree with that Mission Statement. If you would please look at that again to make sure that I have it correctly on paper, I would appreciate it.

DR. FLETCHER: Okay. Let's take a break and come back and discuss the offsite issues, any committee activity. I think the rest of the morning because it's some very important things.

(Short break.)

DR. FLETCHER: Please reassemble around the table.

(Pause.)

The second part of the morning we have a number of issues to deal with, and I am thinking about a time for the next meeting, the framework of the next meeting. It should either be a Wednesday and a Thursday or a Thursday and a Friday, issues

offsite and so forth. And I would like to let Vicky go through a few things that she needs to do at this time.

COL. FOGELMAN: Well, first, I'd like to welcome Dr. Michael McGinnis, who is the Scholar in Residence at the National Academy of Sciences and who is really the person behind the Clinical Preventive Services Guide, which has actually recently been revised and come out. It was discussed yesterday in the Health Maintenance and Promotion Subcommittee. So I welcome Dr. McGinnis.

DR. McGINNIS: Thank you.

COL. FOGELMAN: It's his first meeting, as well, and he wasn't able to make the offsite.

One of the things I'd like to talk about is not just dates for the next meeting but how do you want to conduct the next meeting? Do you just want an Executive Session or would you like to have -- at first I had in mind, and we discussed this a little bit at the offsite, possibly going to an operational base. And Trueman Sharp and I had discussed either Camp LeJeune or Parris Island, Parris Island being the recruit training base for the Marines and Camp LeJeune being a large operational base for the

Marines.

Now, if we do that, I have to give you the caution that we would not be able to spend the entire time in Executive Session. We would have to take some time looking at the operations of the base. So if you prefer to stay in Executive Session for the next meeting, that's fine. I just need to know what you would like to do and how.

Yes.

DR. FLETCHER: Dr. Warner.

DR. WARNER: As a new member, I found the session at the Air Force Academy very, very helpful in just getting a sense of how some things work and a mindset that I'm not so familiar with. And I personally would like that. As a new member, I think I would benefit from more of that kind of exposure.

DR. FLETCHER: Dr. Baker.

DR. BAKER: I think Parris Island would be very appealing from the standpoint of the fact that they're doing the training there and that many of us were concerned yesterday, and even previously, in terms of the ten-percent attrition during training, which is very costly for the DOD and for the

individuals involved. I think that would be a very interesting place to meet.

COL. FOGELMAN: Ditto.

Others?

DR. FLETCHER: Other comments?

Dr. Perrotta.

DR. PERROTTA: I think all of us spend enough time in meetings where we sit and listen and sometimes get to present. What makes this different and more enjoyable and gets me more enthused about the work is on occasion seeing that. At least in the beginning, we went to three in a row operational centers. And I couldn't stop talking about the experience. And I think that helped me garner the energy to continue working on some of the projects.

And I can hope that if we can do that, maybe not three in a row but a couple, that the newer members who will have three or four years in front of them will also see this as a little bit different than just another committee that they're sitting on.

DR. FLETCHER: My comment. Dr. Perrotta became very good at shooting rifles and throwing

hand grenades at me. It was very good.

(Laughter.)

Other comments or questions?

Dr. Barrett-Connor.

DR. BARRETT-CONNOR: As somebody who comes from the other side of the country, how do you actually get -- is it going to take me another half a day to make the connections to get to Parris Island?

DR. FLETCHER: Yes.

DR. BARRETT-CONNOR: What are the logistics of doing that?

PARTICIPANT: Driving.

COL. FOGELMAN: I can't tell you right now, but certainly neither Parris Island nor Camp LeJeune are in large cities. So I suspect it will take a little bit longer to get there. How long, I can't answer right now.

DR. BARRETT-CONNOR: Go to a major airport and bussed in?

COL. FOGELMAN: I suspect you -- I'm not sure. I don't know the answer to that.

DR. GWALTNEY: There used to be an airline called Air South to get you there. I don't know if

they're still flying or not. They barely made it the last time I went.

(Laughter.)

PARTICIPANT: To get to Parris Island, you fly to either Charleston or Savannah and then it's an hour, hour-and-a-half drive.

DR. BARRETT-CONNOR: Well, that's doable. But sometimes you don't tell us that and then it turns out it is -- thank you.

DR. FLETCHER: So from the coast to Atlanta to Charleston and drive.

Dr. Sokas.

DR. SOKAS: Well, I was just going to ask about Aberdeen in the sense that they've got some chemical weapons and issues that they're dealing with there in terms of maybe doing operational stuff of things that are close.

COL: FOGELMAN: I don't think Aberdeen is a very good choice right now.

(Laughter.)

DR. FLETCHER: Dr. Poland.

COL. FOGELMAN: That would be my opinion, at any rate.

Colonel O'Donnell, do you have any comment

on that?

DR. POLAND: I think they are clearly hearing from the Board that they would like to be at an operational base. I think the thing that is most helpful, though, is not to go there and sit in a conference room with the Commander and let him or her tell us about it. Like Fort Bragg, which was probably the defining experience of the old members, get us into the field. Let us talk with the Senior NCO, let us talk with the individuals. I thought that was a fantastic experience.

DR. FLETCHER: I would certainly agree. I think less designated lectures or discussions in a room but more maybe onsite would be as didactic but in a different setting.

Other comments about this? This is very important. I think the type of meetings we have will be judged by your thoughts.

Dr. LaRosa.

DR. LaROSA: I concur with what my colleagues have said, and I particularly agree with Dr. Poland. I think for us to get out in the field and talk to the real people about whom we are recommending, changes or not in their lives, I think

is crucial.

DR. FLETCHER: Dr. Barrett-Connor.

DR. BARRETT-CONNOR: One last clarifying point. I would be in favor of Parris Island because it sounds feasible, but I am assuming we are not doing this in August.

(Laughter.)

COL. FOGELMAN: No.

DR. FLETCHER: We are thinking about March.

COL. FOGELMAN: March or early April. Now, I want to tell you up front that I can't promise Parris Island, although I can certainly put that in as the primary request. Dr. Sharp feels that both Parris Island and Camp LeJeune offer great opportunities for looking at the operational environment.

Camp LeJeune is the home of one of the mobilization forces for the Marines that takes care of Europe and Africa and that whole theater. So you have a whole different set of problems there than you do at recruit bases. But both of those bases would offer a lot, I think, in terms of seeing what the average grunt, if you will, goes through in terms of both training -- and there are some

training opportunities at Camp LeJeune to view as well, some advanced training.

Well, with that in mind, I will certainly tell him that we would like to shoot for that. The second issue is, I really feel that if we go to an operational base that we need to be willing to devote two full days. And at the offsite people said that they felt we should do two full days. But then when we go to set up the meeting, most people want to leave about 1:00 o'clock. So I need to hear from you on what it is you want to do.

DR. FLETCHER: I think better days. I know a lot of you like weekends as I do and would rather come in and have a Wednesday, Thursday meeting, or a different format. Please give us your thoughts on that.

Dr. Poland.

DR. POLAND: End of the week.

DR. SOKAS: But not the weekend.

DR. FLETCHER: You say end of the week, meaning Thursday and Friday, like now?

DR. POLAND: Or Wednesday and Thursday.

DR. FLETCHER: Any other thoughts?

Dr. LaRosa.

DR. LaROSA: I think the thing is, if we go to one of these operational sites, I think it's intriguing enough for what I think the majority of my colleagues are saying, that you would be willing to devote two days to it and the travel time that it's going to take for us to get there, because the opportunity to see some things and talk to folks is substantial. And I for one am certainly willing to do that.

I would also say, too, out of respect for our West Coast colleagues, that there are military sites, I know, out there. And one of the things, and Dr. Poland is going to laugh at this, but I would love to go on an aircraft carrier. I mean, I think that that's probably one of the places I would not like to take up permanent residence because I think there are some real challenges with that, but I would very much like to see that.

COL. FOGELMAN: We had sort of thought at the offsite that we would try to, if we had four meetings a year, that we would try to have two of them at an operational location. If we have three meetings a year, we would probably have one of them in an operational location. So if we do have a

second operational meeting, maybe we can talk to the Navy and see if we could set something up like that.

But back to the two full day issue.

DR. FLETCHER: Other comments on that? Now, we are hearing sort of the end of the week.

Dr. Clements.

DR. CLEMENTS: Well, I think there might be a way to get in as much meeting if we're really isolated in those areas we might be willing to work on evening session or something like that and still allow us to get home. A lot of us have very busy schedules and it's hard to take out four days if you had to travel one day and travel one day back. So that might be a way to get --

DR. FLETCHER: So you're saying like a day and a half, working the night between the day and a half.

DR. CLEMENTS: Right. I would be willing to do that, because I think probably in Camp LeJeune there might not be a five-star restaurant.

(Laughter.)

COL. FOGELMAN: You'll be so tired after you do all those operational things you probably --

DR. CLEMENTS: Or rejuvenated.

DR. FLETCHER: Any other thoughts?

COL. FOGELMAN: What if we said something to the effect that we would continue on until 3:00 or 4:00 o'clock on the second day and then allow you to leave after that? Obviously I can't control your schedules and I want you to attend, but --

DR. FLETCHER: I know what people are feeling. Would Thursday and Friday be okay until 3:00 or 4:00 o'clock for those of you who have children and other things?

DR. BARRETT-CONNOR: I prefer that as a long-distance traveler, because if I'm going to come that far and stay until 5:00 o'clock, then I don't get home until 1:00 o'clock East Coast time. That's in the airport, not to the house, I'd just as soon stay over and come back the next day. My own personal preference is not to have to be in the office on Friday morning at 7:30 when I got to bed four hours before.

DR. FLETCHER: So sort of what are we hearing? Have this meeting on Thursday and Friday?

PARTICIPANT: Yes, I think so.

DR. FLETCHER: I am sort of hearing that.

COL. FOGELMAN: Well, I would like to ask

you that we at least need to be able to stay until 2:00 o'clock. I think if we don't on the second day that we're not going to accomplish anything. I just don't think --

DR. FLETCHER: Well, we are pretty much doing that.

COL. FOGELMAN: Well, no, we are not. A lot of people need to leave at 12:00 in order to make 2:00 o'clock flights. I am saying that 2:00 o'clock would be the end of the meeting.

DR. FLETCHER: No one leaves before 2:00 o'clock.

COL. FOGELMAN: And if we can't live with that, then tell me and we'll make other arrangements.

DR. FLETCHER: Can everyone live with that?

PARTICIPANT: That's fair enough.

DR. BARRETT-CONNOR: I really think for those of us who are travelers it depends on what the connections are.

COL. FOGELMAN: Sure.

DR. BARRETT-CONNOR: And I plan to stay until 2:00 o'clock today and take the 3:30 flight, which with good weather would have been no problem.

But I think it would be risky to leave here at 2:00 o'clock today.

COL. FOGELMAN: Yes.

DR. BARRETT-CONNOR: So I think you can plan very conscientiously to do what you like, but it doesn't always work.

COL. FOGELMAN: Right. Absolutely. And I'm sure that there may be people that have to leave early for whatever reason. I'm just trying to get a general commitment.

DR. WALDMAN: If I weren't on this Board, I would probably never have had the opportunity to visit the Air Force Academy. I can say with almost absolute certainty that I would never have the opportunity to visit Parris Island. And I think that is going to be fascinating and I am going to get a lot out of it. But I want to make the point also that to take those trips and see those things isn't really the reason why I'm here. I want to feel that I'm able to make a contribution to the needs of the Department in terms of epidemiology, in terms of those kinds of things.

And I think the trips are great, but I think the meetings are important also. And I think

that whether we stay until 2:00 o'clock or 3:00 o'clock or 5:00 o'clock, from having been at the offsite in August and at this meeting, I think we would benefit from having the meeting structured maybe a little bit differently. And when we arrive, or before we arrive, knowing exactly what the objectives of the meetings are, what we want to achieve during the course of the meeting, what the process is for arriving, the accomplishments we hope to come out of it.

The agenda should be clear, the time allotted should be commensurate with the kinds of decisions we're being asked to make and so on and so forth. I mean, if we only have two days or a day and a half and we're all very interested in the site visit part of the meeting, it really makes it incumbent upon us to make optimal use of the remaining time to get the stuff of what we're about done.

COL. FOGELMAN: I agree.

DR. FLETCHER: Dr. Sokas.

DR. SOKAS: And I think the stuff of what we're supposed to be doing should be packaged in the middle so that people who get there late or people

who leave there early are going to be missing the site visit as opposed to the meeting. And maybe that's a way people can decide flexibly about their schedules.

DR. FLETCHER: Good idea. Any other comments?

Dr. LaRosa.

DR. LaROSA: One other thing appending on to what Dr. Sokas has said. I understand it's difficult, but if there is something about which we are expected to make a decision or render some sort of a judgment, if we could have it ahead of time to reflect on it.

I think that was the thing that I had hoped to have this time, because I saw some things there that really needed some due deliberation and maybe some discussion with experts in the field that would make us smarter about it, too. With all due respect, I understand it's difficult to do all the things that you have to do, but at least the key items, if we could have that. At least reading on the plane is very helpful.

DR. FLETCHER: Thank you.

Other comments?

Dr. Broome.

DR. BROOME: I would like to recognize that at least this time we did get sickle cell and the hepatitis out in advance. I really think there have been some changes that are responsive to the discussions at the offsite, and I'd like to recognize that.

DR. FLETCHER: We are trying to get these things, such as the procedures that we discussed and so forth, we're working towards it.

COL. FOGELMAN: So we're saying a day and a half? Is that the general consensus?

DR. FLETCHER: A day plus until 2:00 o'clock the next day. A little over a day and a half.

COL. FOGELMAN: All right.

DR. FLETCHER: Please don't leave before 2:00.

COL. FOGELMAN: If we do go to Parris Island, I will have to probably ask you to try to come in the night before. Would that be acceptable?

DR. FLETCHER: That would be on a Wednesday night.

COL. FOGELMAN: Now, as far as dates. We

received dates from some people, a calendar from some people, but not from everyone. But we tried to look at acceptable dates for people based on what we have. The best week appears to be the week before Easter.

DR. FLETCHER: The 27th and 28th.

COL. FOGELMAN: Actually, the week before Easter would be the week of the 24th.

PARTICIPANT: What month are we talking about?

DR. FLETCHER: March.

COL. FOGELMAN: I'm sorry; I thought I said March.

DR. FLETCHER: March 27 and 28 is --

COL. FOGELMAN: Well, actually, the 28th is Good Friday. I was sort of thinking maybe the 26th and 27th. Or, one of the failures we had apparently was we didn't ask you about your April calendars. And if April looks better, we may be able to make it, let's say, the first week in April.

DR. BARRETT-CONNOR: I can't come in April, and I'm giving two lectures on the two days you named in March. But the rest of March looks good.

(Laughter.)

COL. FOGELMAN: It may be that for one reason or the other we can't have everybody attend every meeting. How many people think that the first or second week in April would look better than the last week in March?

(A show of hands.)

That's about half the people.

We could do it separately by week. I am looking at three weeks here: the week of the 24th of March, the week of the 31st of March, which is really the first week in April, and the week of the 7th.

Now, how many people think that the week of the 24th would be best?

(A show of hands.)

DR. WALDMAN: How about rather than best, why don't we see how many find these weeks possible.

COL. FOGELMAN: Okay. That's good.

How many could come the week of the 24th?

(A show of hands.)

How many could come the week of the 31st?

(A show of hands.)

Dr. Fletcher, can you come to either of those?

DR. FLETCHER: I think I can. I'm not voting, but I --

COL. FOGELMAN: Well, you need to vote because I need to know when you can be there.

(Show of hands.)

Okay. 15.

How many can come the week of the 7th?

(Show of hands.)

Well, right now it looks like the week of the 31st is the most open.

DR. FLETCHER: Let's have two alternatives. I think the 31st and --

COL. FOGELMAN: The week of the 7th was the second choice.

DR. FLETCHER: Either of those weekends.

COL. FOGELMAN: What I will do is get with Dr. Sharp and see what might be available as far as operational locations. And I will try to set it up for Wednesday and Thursday, if that sounds reasonable to you.

PARTICIPANT: Actually, Thursday and Friday --

COL. FOGELMAN: Thursday and Friday is better?

DR. FLETCHER: I think we have Thursday and Friday.

COL. FOGELMAN: Okay.

DR. FLETCHER: The 3rd and 4th or the 10th and 11th.

COL. FOGELMAN: All right. But coming in the Wednesday night.

DR. FLETCHER: Yes, unless you can get an early bird deal.

COL. FOGELMAN: All right. Great.

DR. FLETCHER: Anyway, the 3rd and the 4th or the 10th and 11th.

Dr. Sharp.

DR. SHARP: Mr. Chairman, I think this is a good process, and the further in advance we can do it the better, because then if it's on the calendar we naturally try to protect that time. And all of our calendars fill up six months in advance.

COL. FOGELMAN: With that in mind, Jean has given me two possible dates for July, which are either the 17th and 18th or the 24th and 25th. Those are the ones that came out the highest as far as the calendars that we received. If you maybe could take a quick look there, and we will take a

vote here in just five seconds.

DR. JOSEPH: 10th and 11th, 17th and 18th.

COL. FOGELMAN: No, 17th and 18th or 24th and 25th.

DR. JOSEPH: Sorry.

COL. FOGELMAN: According to her.

DR. FLETCHER: Are those --

COL. FOGELMAN: Yes.

Okay. How many people as of now think they can make it the 17th or 18th?

(Show of hands.)

DR. FLETCHER: I'm afraid I can't make it.

COL. FOGELMAN: Well, if you can't make it, we probably won't have it then.

How many could make it the 24th and 25th?

(Show of hands.)

How many could make it the 10th and 11th?

DR. BAKER: Of August?

COL. FOGELMAN: 10th and 11th of July.

DR. FLETCHER: I can't make it.

COL. FOGELMAN: Okay. You can't make it.

Well, I think if Dr. Fletcher can't make it, we --

DR. FLETCHER: I could probably make either

of those previous ones.

COL. FOGELMAN: All right. Right now it appears that the 24th and 25th are the best dates for July.

DR. FLETCHER: There was an alternative, though.

COL. FOGELMAN: We have the 17th and 18th.

DR. FLETCHER: So let's leave that as a possible.

COL. FOGELMAN: So if you can, try to bank on at least the 24th and 25th.

DR. LaROSA: Vicky, could we try the next one out after that?

COL. FOGELMAN: I'm trying.

DR. LaROSA: Okay.

COL. FOGELMAN: Okay. The next dates that I was given were October 23 and 24 and November 13 and 14, as far as our final meeting. So if you could quickly look at your calendar there.

PARTICIPANT: Which?

COL. FOGELMAN: October 23 and 24 or November 13 and 14.

Okay. How many people as of now could make it the 23rd and 24th of October?

(Show of hands.)

How many people could potentially make it November 13 and 14?

(Show of hands.)

All right. We may need to look at those dates again. Right now I don't know if we have a quorum for either of those two dates. I will go back, and we will send calendars out again for those dates. But we will shoot for at least July 24 and 25 as it stands now for our meeting after March. And for March we will look at the two possible dates --

DR. FLETCHER: April.

COL. FOGELMAN: I'm sorry, April, that we talked about initially.

Thank you very much for helping me with that.

DR. FLETCHER: Those are housekeeping chores. Now, anything else in those arenas?

COL. FOGELMAN: Unless anyone has any additions to the Executive Summary. And actually if you just want to call those in, that's fine. Because I would like for us to be able to go back into committee session today.

The Surveillance Committee will definitely need to meet today. And for those people who are not on the list that I originally handed out that want to be a part of that committee, please join with Dr. Chin and he will take the names and give me a list at the end.

Also, the other committees, I think, have not completed their work. And what I would like to have is a product, if possible, before you leave. What would you like to take on over the next year of the issues that were listed as primary issues for your group by the Preventive Medicine Officers.

And I have asked them to stay here to help you, answer questions, or work with you on that. They can give you some good input into what they think are really the issues based on the people they have talked to within their services.

That's really where I'm heading, because I can't prepare things for you if I don't know where you are going.

DR. FLETCHER: These are issues the committees are currently discussing: G6PD, Hepatitis A, Clinical Preventive Services, and adno virus, I believe. We need to have some type of

formal response. I think all of the other things, the issues that we need to address for future activity and so forth is the other thing.

COL. FOGELMAN: I think that even if you don't give me something in writing on the two questions that came up yesterday today, if you get me that within the next week or two, that will be fine.

DR. FLETCHER: Dr. Schaffner.

DR. SCHAFFNER: Does the committee as a whole want a quick oral summary of the Infectious Disease Subcommittee?

COL. FOGELMAN: Oh, yes. Are you already finished with that?

DR. SCHAFFNER: Yes.

DR. FLETCHER: Why don't we do that, all the committees around just to brief whatever we have to say.

COL. FOGELMAN: Sure. I didn't realize you were that far along.

DR. FLETCHER: Dr. Schaffner.

DR. SCHAFFNER: We addressed several issues. Let me tell you what we decided on several. First was the G6PD issue. We've divided it into

two clear questions. One, the issue of screening, when, how, whether, whom. And the other is as stated in the agenda, the question of testing before Primaquine therapy is given.

The committee decided that it did not have enough information yet to make a decision clearly, wanted some more information. And we anticipated that this was going to probably be the subject for a kind of decision analysis. And of the subcommittee, Dr. Waldman agreed to work with a, or several, preventive medicine officers in order to bring that forward.

COL. FOGELMAN: Are the services picking up on this?

DR. SCHAFFNER: I can send you a note of that, too, of course.

COL. FOGELMAN: All right.

DR. SCHAFFNER: The second issue, an easier issue. It's much easier. It had to do with whether you can mix and match Hepatitis A vaccines. I would like to say the short answer was yes, the longer answer was sure.

(Laughter.)

However, two further points. One, the

services would seem ideally suited in order to actually get the data which would be useful, such as they already have in part, to answer this question both for themselves and for the civilian sector. And this would appear not to be a difficult or elaborate study. So we recommend that such a study be done and the results reported back to us.

Point B is that the comments made yesterday at the meeting seemed to be sound. And using the CDC model, we are offering some unsolicited advice and suggestion that a dual source contract be developed, that this seems to be in both the interest of the services as well as the entire civilian sector when it comes to the sale of Hepatitis A vaccine. That's number two.

Number three, we did discuss briefly whether the AFEB ought to at this moment get its oar in yet again on the issue of adno virus vaccines. And after deliberation, and particularly with Dr. Gwaltney's advice, we continued to have confidence in Dr. Gwaltney and his interactions continuing on this subject. And it would appear as though a process is in train that we see no need to influence at the present time.

So we are going to continue to take information on that and have a strong interest in the surveillance system that will be set up. And Dr. Gwaltney is going to keep a continuing interest in this area.

DR. FLETCHER: Dr. Gwaltney.

DR. GWALTNEY: I certainly have a continuing interest and will keep it. I don't want it to appear that I have the sole responsibility for this group to see that -- to try to see that we get the vaccine. There maybe is a thing or two that can be done in terms of contacting people and suppliers, and I'm willing to do that. I think it would be worthwhile for the Board to make the recommendation again that this be done, that the vaccine be procured as quickly as possible. I think that should go into the record.

DR. LaROSA: Absolutely.

COL. FOGELMAN: Bob, did you want to make any comments on this?

DR. SCHAFFNER: The debate yesterday was that this seemed to be already in train and we didn't need to do that. But I don't think, speaking for my subcommittee, that we would be in any way

distressed to reinforce the notion that the vaccine purchase be moved along expeditiously.

DR. FLETCHER: I think reinforcement is --

DR. SCHAFFNER: I'd like my colleagues on the subcommittee to speak up here.

DR. FLETCHER: Dr. Clements.

DR. CLEMENTS: We just were struck that the estimated cost of the G6PD screening was $10 a test. And the issue of raising the cost of the vaccine to $10 for the vaccination to us just seemed that that cost factor really was not much of an issue if you're really interested in prevention of serious disease. So we would really like to urge that a solution be found to produce the vaccine. And I guess I was a little worried about where that really stands.

I think there is some discussion with industry, but there also seems to be some concern about the actual cost of the vaccine. But when you lay that out with the cost of many other of the preventive measures that are being recommended for screening and so forth, it's not that costly.

DR. FLETCHER: Other comments?

Dr. Warner.

DR. WARNER: Just one. It's merely a thought. I don't know enough about the vaccines or the diseases or anything. We've been talking about two different vaccines for two different diseases here. We've been talking about them as if they're entirely separate issues. And I think they can be separated, but it's not clear they have to be.

We're talking about an orphan vaccine in this one case, it sounds like. Well, so far, I understand, there is no producer at the moment. But it sounds to me that $2.5 million is not a lot of revenue for a manufacturer. That's not something that is going to be real attractive to them one way or the other.

We just voted or endorsed the notion of having dual production of the Hepatitis A vaccine, but it would be possible to try to tie the two together and ask a drug manufacturer to come in with a bid on the two of them together. And you might find yourself getting a better price on both of them that way.

DR. FLETCHER: Dr. Clements.

DR. CLEMENTS: As we understood it, they have put out a request for proposals for the adno

virus, and they'd only gotten a single bid. And it's not a trivial issue to those of us who know about vaccines. And establishing a production facility for that vaccine and then enteric coating it is going to require some retesting of the vaccine so it's not going to be like putting out another drug or something.

So that process has to be initiated. And it's a bit of a risk for a company to do that because they don't know if they can actually produce a product that is going to be equivalent to what was licensed before. But I think since it is a high risk venture that there should be a willingness to meet the manufacturer halfway and pay what would be in 1997 a reasonable cost for a vaccine.

All new vaccines that are made in GMP facilities now that require all the occupational and all of the regulations that are imposed now on manufacturers are going to cost more money than vaccines that were made back in the '60s and '70s. So I think that's what the new manufacturer is going to be dealing with, is complying with all of those new regulations. And there's not going to be any new vaccine out today that's going to cost under $10

a dose.

DR. FLETCHER: Other comments or questions?

Dr. Barrett-Connor.

DR. BARRETT-CONNOR: Is it possible for -- product manufacturing the whole package to somebody else and that have to go through a whole new FDA --

DR. CLEMENTS: No, the facility itself has to be approved. It's part of the FDA process.

DR. BARRETT-CONNOR: The building.

DR. CLEMENTS: The -- consistency, lot production, everything has to be re-established in a new facility. And the enteric coating is something that from other live vaccines is not a trivial issue either. You can eliminate the potency of that vaccine just by enteric coating it. So that know-how, that knowledge base, is not available on the open market. It's not a prescription. So it's going to take a lot of working to get a company to take all that on with the risk.

And I think it is important. I would say that it's not necessarily an orphan vaccine. If there are four deaths in a nursery and there are going to be more of these and they have surveillance where people can actually find out what's killing

these infants, it could become important to the vaccine for civilian use.

DR. FLETCHER: Thank you. Other comments?

Dr. Schaffner.

DR. SCHAFFNER: The last point is a look to the future. And it was clear that the committee was enthusiastic about reviewing the immunization program of the several services and thought to do so in an incremental fashion, being first interested in the immunization program of recruits. And next after that, the immunization programs of active duty personnel, and extending to that the immunization program that the services have for special deployment and also for dependents.

We ask that a process be put in place so we can begin to receive information, important point, formatted in such a way that we can compare the procedures across services.

We are perhaps a little sensitive at this meeting, not terribly interested in oral presentations, but perhaps, and this might be the role of a one-time independent contractor who can gather all that information and format it in such a way so that it can be presented to the members so

there will be some ease in looking this over so that both consistencies and varieties of approaches can be looked at so that the Board can -- in other words, the information ought to be formatted in such a way so that the obvious questions that the Board has can be addressed.

Three members of the subcommittee, in particular, have volunteered themselves -- Dr. Clements, Dr. Cladd Stevens, and Dr. Greg Poland -- to be on the point from the point of view of the subcommittee to work with the staff on these issues.

DR. FLETCHER: Dr. Allen.

DR. ALLEN: Bill, a group that we talked about last night that you didn't mention this morning were reservists.

DR. SCHAFFNER: I didn't intend to be comprehensive, but, please.

DR. ALLEN: Vicky is taking notes. That might be something. To the extent that reservists at the time of their -- if they're coming in and are primarily accessed as reservists as opposed to retiring or leaving the active duty and then going on to reservist, what are the differences there and --

COL. FOGELMAN: Right. It would help me a lot if people who have identified themselves as being on point would get together and write something down as far as exactly what you want from me and in what order.

DR. CLEMENTS: I think that we could that either if we have time today or we could draft something and circulate it among ourselves and then send it to you.

COL. FOGELMAN: Okay. That would be great.

DR. FLETCHER: Dr. Schaffner.

DR. SCHAFFNER: That ends the reading of the --

DR. FLETCHER: Any comments or questions for Dr. Schaffner's committee?

Dr. Perrotta, do you have any --

DR. PERROTTA: Our committee expressed interest in reviewing the existing Department of Defense models for conducting environmental health surveillance. And we would like to work with each one of the services to take a look at what is written.

We understood that there is a draft not yet signed, a DOD surveillance document, that is

currently under review and under the signature process that we'd probably like to see. So we would be willing to work with each one of the services to make sure that we have a consistence and useful where it is useful to be consistent.

We learned yesterday in a variety of formats that things in the Navy may not directly apply to things in the Marines and things in the Air Force, et cetera, as far as environmental hazard surveillance. So we wanted to do that as requested in the list of the top priorities.

We wanted to make sure that there was some follow-up on the injury in military report, some of the recommendations. All of us agreed that we needed to go back and re-read it or read it and that our committee would get back with you with some ideas on recommendations. And we would certainly be working with Colonel Jones. And I suspect that Professor Baker would be more than willing to continue her leadership role in doing that.

We were impressed with, I think, the information shared yesterday on the environmental hazard surveillance that has been going on in Bosnia. It seemed to us to be a major improvement

over what we've learned has occurred in other deployments. And we would be looking to seeing that those kinds of comprehensive planned out hazard surveillance projects would be done, and that would fit in reviewing the existing models and making recommendations for a standard surveillance.

We wanted to also make sure that we would consider issues of biomonitoring. I think we wanted to expand this environmental hazard surveillance, not just to measuring things in the environment but also taking a sensible and clinically appropriate approach to the collection of, for example, biological samples for the purpose of environmental hazard surveillance.

I don't think we want to line up a soldier who is supposed to be fighting a war and getting him or her in a clinic when they need to be doing their work, but there are other ways just to get a sample for us to say just in case something goes on. But indeed if there are some thoughts, some hazards identified, some concerns identified, that we can do some special kind of approach. And I think we want to do a little more thinking about that.

And we thought it would be nice to have

access to what can be made available to us given the issues of security, et cetera, for the deployments, and that perhaps a conference call or even a meeting in the next six months or so to bring some of these issues to a head. Following the model that Bruce Jones had for the injury working group may be something that we will be wanting to talk to you about.

DR. FLETCHER: Other questions or comments?

COL. FOGELMAN: I would like to ask that each subcommittee Chair, if you wouldn't mind giving me something in writing as a follow-up. That would help.

DR. FLETCHER: Any comments or questions for Dr. Perrotta?

COL. FOGELMAN: If anyone from Health Affairs or the services wants to pipe in here, please do.

DR. FLETCHER: Please do, anyone.

COL. FOGELMAN: If you think that some of these things are objectives that are unattainable from your standpoint, you need to tell us that.

DR. FLETCHER: Let's move on to Dr. LaRosa's new committee. I can chime in. Judy, if

you like, why don't you comment on maybe what we did yesterday and I can add a few things.

DR. LaROSA: First of all, I was delighted that the Preventive Officers who joined us were there. And one thing I would like to put in a plea for is if we could have, if we don't already have, names and addresses of them. I fully intend to come back and talk with them, because I found their input enormously useful.

We didn't get to the tasks we were assigned yesterday because we had to deal that which was in your package and which Colonel Fogelman sent out to you ahead of time, which was titled Appropriate Clinical Preventive Services That Should Be Provided as a Routine Benefit.

We spent our time going over that. And the group felt quite keenly that while the information that was there was useful, that we really needed to go back to the baseline and get information on which to base these preventive services and not try to reinvent the wheel.

So when we went down the list of all the screening things, we thought we would go back to the base which was the clinical preventive practices

that came out from the Public Health Service. And we are most fortunate to have Dr. McGinnis with us so that he can serve as a tremendous resource to us. But we thought we would go back to those and we will come back to you with a new format for this.

One of the things that we felt quite keenly about is that what we are talking about here are routine clinical preventive services. Because immediately as we began discussing, we got into the whole issue of active duty, reserve, those who are being deployed, and dependents. Clearly several different groups. And we also put in there pregnant women, too, because there's another group yet.

So how we are going to frame these routine preventive services for each of these groups we will come back to you on. In the meantime, however, we feel quite strongly that should you have anything to add, suggest, recommend, that if you'll send them to me, please do so.

DR. FLETCHER: Dr. Broome.

DR. BROOME: I'm sorry to present this now, but actually I asked one of the staff of the CDC to line up the military and their task force recommendations.

DR. LaROSA: Thank you very much.

Before I go on, let me ask my colleagues on the committee if you have anything to add, subtract, amend to my comments.

DR. McBRIDE: Dr. McBride at View Med. I wasn't on the committee, didn't have a chance to comment on what you have spoken about. But when you were considering those preventive services, I don't know if you know that at this time last year Dr. Joseph released a listing, I believe it was from Health Affairs, a listing of clinical preventive services that were to be offered by Tricare Prime. And it listed a series of those.

And the Navy has embraced those as a level of preventive services that they are going to provide to all their beneficiaries so that they are the exact same as the Tricare Prime providers. So I think perhaps the AFEB should look at that document and be on the same sheet of music, so to speak, and follow the uniform listing of those.

Many of those seem to correspond with the recommendations from the United States Preventive Services Task Force. But perhaps we could provide that to you for your review.

DR. LaROSA: Let me ask Dr. Fletcher on how this came to --

DR. FLETCHER: Tricare Prime, Mike Parkinson worked with me on utilizing that data and a few other things to put together this very preliminary list. About the middle of last year Dr. Joseph wrote us directly asking for exactly what Judy -- I guess a different approach for what we are discussing today. So this has been asked by his request to provide this response.

So I think we are incorporating and sort of redoing some of this exactly as you say, which Mike had a lot of input in. So I think we have all that, but if you could sit in with us, I think you would be helpful to make sure we are doing that.

LT. COL. EGGERT: Just to piggyback on that. That Tricare Prime Prevention package was -- there was an attempt to try to utilize the Preventive Services Task Force recommendations. It doesn't entirely follow that. The other thing is that these recommendations are not static. As evidence comes in from new studies, those recommendations are going to change over time and we need to be aware of what the latest science is. So

it's going to have to be looked at on a continuing basis. The recommendations may change.

DR. LaROSA: Well, I quite agree with you on that. And I think one of the other things that came up in the meeting was how one delivers these routine preventive services. There are in the different services, to the best of my understanding, different times that they are delivered that one gets an annual physical or it's an every five-year physical or there's a baseline and then one of these things happen.

So it's no good to say you need to do something at "x" point if the military personnel isn't in with the physician having anything done. So I think that's one of the things that we need to consider in our recommendations.

One of the other things that I would like to add, and this goes back to Dr. Schaffner's committee. You were talking about immunization treatment. That's one of the things that we were to consider. And I think that what I would like to suggest, although our subcommittee has not had an opportunity to talk about it, is maybe if a member of our subcommittee could be working with you on

that.

If you look at the second page of this document that we have, or the two pages that we have, it has a whole list of immunization treatment, and I don't think we should be working against you.

DR. FLETCHER: That's a good idea.

DR. LaROSA: So, unless someone wishes to leap forward from our committee and wish to serve on it, we will appoint them later.

DR. FLETCHER: Other comments or questions?

(No response.)

Beyond what Dr. LaRosa has mentioned about these recommendations, we have been tracking the Air Force's progress with their aerobics testing system that Mike Parkinson has spoken about a number of times, and we will be addressing, probably, as issues of the priorities on fitness for duty issues and healthy lifestyle behavior choices. These are other areas we will be going more specifically into once we finalize what has been presented. So these will be some later challenges.

DR. LaROSA: I would add one more thing, proselytizing for health maintenance and promotion, because I do think that it cuts across everything

that we do in any one of the other committees. If you can't get folks to do whatever it is that you want them to do, it ain't going to work.

So I think one of the things that I would like our committee to think about, and one of the things that I would urge each of you in your committees to talk about, is how do you get the information disseminated to those you want to take action on it and then how do you get them to take action.

It's a very important issue. And, of course, you know from our ability to get everybody in the United States to stop smoking it's really very easy.

DR. FLETCHER: Other questions or comments?

COL. FOGELMAN: I have a couple of comments.

With that in mind, we will be bringing a new member on to the Board as soon as we can get the paperwork through, and I think all of you new members know how laborious a process that is, one of the things I've been unable to change very much in this large bureaucracy. But Dr. Neal Weinstein will be coming on as an expert in health behavior in the

near future. So if any of the subcommittees would like to use his expertise, he's very interested in helping in any way he can.

Also, when you break out into your committees today, and it sounds like some of you have more work to do than others, but at a minimum could you please select an assistant Chair and let me know who that person is. Because that way if the Chair can't make it to the meeting, we can have an assistant Chair.

It sounds like you all got a lot of work done in a fairly short period of time. I'm going to give you time now to meet again with your committees and finish up any unfinished business that you may have. And I would request that each committee would give me something in writing. If not today, at least within a week or so, so I know how we need to proceed here.

DR. FLETCHER: By that statement, we will meet in committees and then adjourn after that without another group meeting.

DR. LaROSA: Yes. I think some of you have signed up for transportation with Ms. Ward to the airport. Please verify whether or not you need to

use that transportation. And if you haven't signed up with her, we need to know that, because we're going to be working from the sheet of music that we have right now otherwise. So please let her know fairly quickly if you have signed up or if your plans have changed.

DR. FLETCHER: Dr. Chin.

DR. CHIN: Inasmuch as the Epidemiological Systems Ad Hoc Subcommittee is drawn basically from all of the other standing committees, we didn't meet yesterday. But I think we need to get a couple of points clarified with regard to the operations of this ad hoc committee.

First, yesterday Colonel Jones presented his thoughts on development for the sort of surveillance system in the military, and he outlined really potential roles of the AFEB. From reading this, I assume that there must be something ongoing in the military for the development of a surveillance system. And I don't want to reinvent the wheel when we eventually get the ad hoc committee together as to the process.

Are there sort of developments in --

COL. FOGELMAN: Well, Health Affairs has

set up a group, which has not met yet, by the way, to start identifying core data elements and help maybe make a tentative strawman for a surveillance systems. And that's one of the reasons I wanted Bruce to talk to you yesterday, but because of time we sort of cut it short.

I wanted him to try to tell us how can we fit in with that particular group. And I think that one of the things he wants us to do is, he would like the AFEB to help to validate what that group comes up with.

DR. CHIN: That's a totally different type of role than for the AFEB to almost begin the development process.

COL. FOGELMAN: Right. Right. I think this bears some more discussion.

DR. CHIN: Yes.

COL. FOGELMAN: So if you have a chance today to meet with your subcommittee members and maybe from your standpoint define what you think you could accomplish, let's say, within the next year or so, that would be useful.

DR. CHIN: Maybe the best thing to do would be somehow for me to get connected by telephone or

e-mail with that group.

COL. FOGELMAN: Okay.

DR. CHIN: Because I think one of the first things that needs to be developed, it says to establish objectives. And I think that's clearly number one.

COL. FOGELMAN: Right.

DR. CHIN: And the way I would approach is also to begin development of some output, sort of what you would like out of the system and then build the system sort of like backwards.

COL. FOGELMAN: Exactly.

DR. CHIN: But again, if there's a group that's already charged with this, I don't want the AFEB to set a goal to --

COL. FOGELMAN: Absolutely. And that's why I was trying to -- I knew that this area was going to be the most sticky, because I knew that this DOD group is just standing up.

Gary, do you have any information on --

DR. PATTERSON: There has been a group of preventive medicine and public health officers from the services that have been working for some time putting together a comprehensive medical

surveillance plan concept primarily related to deployment. We're in the final stages of a DOD directive and instruction which addresses this issue.

I think, and I wasn't here for Colonel Jones's presentation, deployment surveillance is one component of overall surveillance issues currently being contemplated within the Department. Obviously, there is interest in occupational health surveillance, injury surveillance, global emerging diseases surveillance.

We will be happy to share with you copies of the draft directive and instruction that was put together for deployment surveillance. I think that it would be useful or helpful for you to interact with members of the Joint Preventive Medicine working group that's been working this in conjunction with Dr. Jones's group.

So there are some initiatives currently in play that do overlap, and I would be happy to share with you the current status on those. I think it would be helpful for you to see where we are so you would have a sense of what's been done today.

COL. FOGELMAN: I really didn't want us to

jump off the cliff here before we -- I don't even know everything that's going on right now. But certainly I think the deployment surveillance plan is much further along than anything else we're doing.

And I know that Dr. Patterson is more than willing to share with you the draft as it exists right now. Most of you have seen some previous draft of this, but I think it has changed somewhat from the last time. That could be a first step. Beyond that, this whole thing of developing DOD surveillances is a very large and going to be a labor-intensive process.

DR. FLETCHER: Dr. Broome.

DR. BROOME: Not to complicate it further, but in the interest maybe of helping, I would like to mention an activity that Health and Human Services is charged with doing. Under the Kennedy-Kassebaum Health Insurance Affordability and Accountability Act there are a set of provisions for "administrative simplification," which charge HHS with leading a process, including all private sector partners and everybody else, in a standardization effort for particularly medical transactions.

It is on one level electronic commerce standardization, but it includes the diagnostic codes. So it clearly spills over into health outcome and standardization. And there will be an official invitation to the Department of Defense to participate. And we have just gone through an exercise of sort of setting up a structure within the Department as to how that's going to happen.

It's actually on an 18-month timetable for implementation, which is going to be extremely difficult to meet. But I think in terms of using the health outcome databases of the military, it would make all kinds of sense to have that aligned with the efforts for the civilian side.

DR. FLETCHER: Dr. Perrotta.

DR. PERROTTA: One point that I failed to mention during the report of our subcommittee was the fact it was clear that there would be overlap when it came to environmental or injury hazard or outcome surveillance with the activities that would be fitting in for infectious disease surveillance.

So while we may come up with some ideas that we would be interested and willing to participate jointly with Dr. Chin and the remainder

of his group when it comes to a big document amount surveillance, it needs to be more than just an infectious disease surveillance effort.

COL. FOGELMAN: All right.

DR. FLETCHER: Other comments or questions?

COL. FOGELMAN: Dr. Chin, do you plan to get the subcommittee together today at all?

DR. CHIN: Well, there isn't that much to discuss, other than perhaps trying to select a Co-Chair.

COL. FOGELMAN: Okay. What I'll try to do is see if I can't get you in touch with both Dr. Jones and Health Affairs, and maybe by talking with them together we can work out exactly where the AFEB needs to interface.

DR. FLETCHER: Our official adjournment time is actually 2:00 o'clock. Let's break out into committees and provide as much as you can back to Colonel Fogelman before you leave.

DR. CHIN: Could I just ask the members that are on the ad hoc committee to perhaps meet for five minutes before they go to the other ones, because otherwise they will be lost. Anybody who would like to join this sort of ad hoc committee is

welcome.

COL. FOGELMAN: I would like some of the Preventive Medicine folks to maybe sit in with them, too, for about five minutes.

(Whereupon, at 10:52 a.m., the meeting was adjourned.)

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